BLOOD DONOR QUESTIONNAIRE

Name: .................................................. degree: __________________________ Date: _______________ Number of arrival: ____________

Birth Register Number: __________________________

Please fill in the data below responsibly and completely. **Circle the correct answer!**

Please read carefully the “BLOOD DONOR INSTRUCTIONS” before filling the questionnaire in.

1. Have you acquainted with the information about risk behavior from the point of view of blood donation and do you understand it? .............................................. yes no

2. Do you belong to a group permanently excluded from blood donation? .............................................. yes no
   (Stay in Great Britain or France in 1980-96 for more than 6 months; treatment with human growth hormone or other medicaments proceeding from the hypophysis or salivary glands; surgery with the use of a dura mater graft; transplantation of the cornea or the tympanum; classical or variant Creutzfeldt-Jakob disease in you or among your blood relatives; practicing sex between men; application of intravenous / intramuscular drugs.... see “BLOOD DONOR INSTRUCTIONS”)

3. Are you going to donate blood or its components for the first time? .............................................. yes no

4. Do you tolerate blood taking well? .............................................. yes no

5. Have you traveled abroad during the past 4 weeks (cold, diarrhea etc.)? .............................................. yes no

6. Have another transfusion department ever refused you as a blood donor? .............................................. yes no
   Reasons: ..............................................

7. Does your profession or hobby require increased physical exercise or demands for attention? .... yes no
   (professional driver, pilot, work in heights, mountaineering, diving, etc.)

CURRENT HEALTH CONDITION

8. Do you feel healthy? .............................................. yes no

9. Do you take any medicaments regularly? .............................................. yes no
   (please cite all of them, including e.g. aspirin, oral contraception)
   What: ..............................................

10. Have you taken any medicaments during the last 4 weeks? .............................................. yes no
    What: ..............................................

11. Do you sweat excessively during night, do you observed elevated temperature, swollen nodes? .... yes no

12. Have you been losing weight recently without any obvious cause? .............................................. yes no

13. Are you treated or observed for any disease (including infections) ? .............................................. yes no

14. Have you suffered any disease during the last 4 weeks (cold, diarrhea etc.)? .............................................. yes no

15. Have you undergone tooth extraction or a minor surgery during the last 7 days? .............................................. yes no

16. Have you had a tick bite during the last 4 weeks? .............................................. yes no

CHANGES IN THE HEALTH CONDITION

17. Have you undergone during the past 6 months:
   a. A surgery, injuries treated in a hospital, stay in a hospital, intravenous application of medicaments? .............................................. yes no
   b. Endoscopic examination or introduction of a catheter, contact with another person's blood (through an injury or mucous membrane)? .............................................. yes no
   c. Transplantation, or have you received blood transfusion? .............................................. yes no
   d. Treatment for a venereal disease? .............................................. yes no
   e. Tattooing, acupuncture, ears perforation, piercing? .............................................. yes no
   f. Vaccination? .............................................. yes no
   If yes, what and when: ..............................................

18. Have you been in a close contact (in the family, at work) with a patient suffering hepatitis, AIDS, another infectious disease, or with a person abusing intravenous / intramuscular drugs? ........ yes no
   What disease: ..............................................

19. Have you traveled abroad during the past 6 months? .............................................. yes no
    Where? (Including for a short time, tourism): ..............................................

20. Do you work in dangerous environment (infectious, harmful to death)? .............................................. yes no
    What (infection, radiation, chemical risks etc.)? ..............................................

21. Have you been vaccinated against rabies or type B hepatitis after exposure to infection? ........ yes no
DISEASES EXPERIENCED IN THE PAST, ANAMNESIS

Have you experienced any of the following diseases/conditions?

22. Hepatitis, tuberculosis, a venereal disease (syphilis, gonorrhea, AIDS), other contagious diseases
   (inf. mononucleosis, tick encephalitis, brucellosis, tularemia, toxoplasmosis, listeriosis, borreliosis,
   typhus, paratyphoid fever, malaria, babesiosis, kala-azar, leishmaniasis, Chagas disease, leprosy,
   Q fever, HTLV I/II virusinfection) or carriership of these infections ........................................ yes no

23. Diseases of heart and vessels, high or low blood pressure ...................................................... yes no

24. Blood diseases (anemia, hemorrhagic diathesis, polycytemia, thalassemia, etc.) ...................... yes no

25. Digestive tract diseases (ulcer disease, pancreatitis, enteritis, etc.) ........................................ yes no

26. Endocrine glands diseases (diabetes, metabolic disorders, thyroid gland etc.) ........................ yes no

27. Kidney diseases (inflammations, calculi, colic, etc.) ................................................................. yes no

28. Breathing organs diseases (asthma, emphysema, chronic lung disease etc.) ............................ yes no

29. Diseases of bones and joints (arthritis, rheumatic fever, osteomyelitis, etc.) ........................... yes no

30. Tumors ........................................................................................................................................ yes no

31. Nervous system diseases, eye diseases (spasms, epilepsy, sclerosis multiplex, glaucoma) ........ yes no

32. Immune disorders, severe allergies, dermal diseases ................................................................. yes no

33. Surgeries and major injuries, transplantations .......................................................................... yes no

What, when: ........................................................................................................................................

34. Blood transfusions (when and where) ? .................................................................................. yes no

35. Have you ever taken the following medicaments (see “BLOOD DONOR INSTRUCTIONS”):
   isotretinoin (Accutane), etretinate (Tegison), aciretin (Neofigason), finasteride (Proscar, Propecia),
   dutasteride (Duo-dart) ? ........................................................................................................ yes no

36. Mental diseases (depression, psychosis, etc.) ........................................................................ yes no

37. Have you ever been treated for alcoholism or drug addiction ? .............................................. yes no

38. Have you ever used illegal intravenous / intramuscular drugs ? .............................................. yes no

39. Were you born abroad or have you lived abroad for a long time ? ........................................ yes no

Where, when....................................................................................................................................

40. For women: Number of pregnancies ................... Last pregnancy in (year): ..................

I confirm I have not concealed any important facts and all data given are correct (concealment of facts
that could endanger health or life of the patient receiving transfusion are punishable in accordance with the
law).

I have acquainted with the “Blood Donor Instructions”, and I understand its content. I consider myself as a convenient
donor whose blood should not endanger the recipient’s health within the meaning of the “Blood Donor Instructions”.

I have been instructed about the course of blood taking and the risks related thereto and I agree with blood taking.
I have been instructed that I have the right to ask questions regarding blood taking and to withdraw from blood taking
anytime. I have been instructed about the possibility of discrete self-disqualification. I also agree that my blood shall be
examined using all necessary tests, including AIDS test, and that it may be used for other than transfusion purposes
within health care in the case of unsatisfactory results. I have been instructed that I will be informed in the case of
unsatisfactory laboratory examination results. I declare that I have not come to donate blood because of AIDS
examination.

I agree that my personal data and my health state data shall be recorded subject to obligatory confidentiality pursuant
to the law in force, and that they shall be used within the transfusion service (e.g. reference laboratories for infectious
diseases, register of excluded blood donors, register of blood donors with unusual blood group etc.) subject to medical
secret principles.

I agree that my personal data may be disclosed to the Czech Red Cross for the purposes of donors’ awards.

I agree that medicaments made from my blood (or serum) may be used for treatment of patients in accordance with
medical, ethical and humanitarian principles within the legislation in force only in case they comply with the requirements
of their safety and quality. In the case of excess of medicaments manufactured in the Czech Republic, I agree with their
export for the purposes of treatment of patients in other countries.

I am aware that I should have a rest for at least 30 minutes after blood taking before I participate actively in the road
traffic.

Date .............................. Donor’s signature ..........................................................

EVALUATION OF THE QUESTIONNAIRE BY A PHYSICIAN

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<tr>
<th>Satisfies □</th>
<th>Dissatisfies □</th>
<th>Dissatisfactory because of: ..................................................</th>
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<tr>
<td>Date:</td>
<td>Physician’s signature:</td>
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